GASCO
GEORGIA SOCIETY OF CLINICAL ONCOLOGY

Audits

The Oncology Target

Test your knowledge with an interactive session!

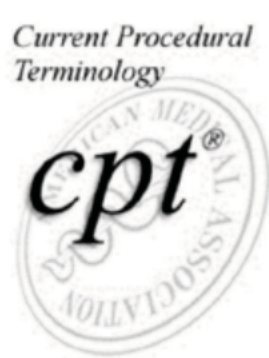
Disclaimer

- This presentation provides ***general*** information and is not intended to provide clinical, legal, or financial advice; it is for informational purposes only. Oncology practices will need to do their own research and make their own decisions when seeking reimbursement

- Regulations and policies concerning Medicare reimbursement are a rapidly changing area of the law. While we have made every effort to be current as of the issue date, the information presented may not be current or comprehensive when you review it or may contain inaccuracies or typographical errors

- Please consult with your legal counsel for any specific reimbursement information

AMA CPT



Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not par of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Demographic Information

- Tell me about yourself…..

1. I am a healthcare provider
   (Physician, Midlevel Provider, Nurse, e
2. I am an administrator/office manger
3. I am a biller
4. I am a pharmaceutical representative
5. I am something else or have no idea who I am or why I am here!

Why Should I Learn This Stuff?

- Compliance – Fraud and Abuse
  - If YOU have responsibility for providing services billed to a payer, documentation, coding or billing, you have a responsibility to understand the rules

  - From the Office of Inspector General website:

* * * * *

Should know or *should have known* means that a person, with respect to information—

(1) Acts in deliberate ignorance of the truth or falsity of the information; or

(2) Acts in reckless disregard of the truth or falsity of the information. For purposes of this definition, no proof of specific intent to defraud is required.

* * * * *

Compliance – Fraud and Abuse

- Could I be implicated/charged with fraud and abuse if the policy was published by CMS but I never saw it?

1. YES
2. NO
3. Not if they can't find me!

Compliance – Fraud and Abuse

- Answer: Yes, it is possible to be held liable
  - If instructions concerning the coding or billing practices in question have been published and disseminated by the federal government or your fiscal intermediary (such as in a provider bulletin), you "should know."
  - If the issue is addressed in official ICD-9-CM coding guidelines (as published in *Coding Clinic*) or in the CPT rules (contained in the CPT book), you "should know."
  - Lack of personal knowledge because the provider bulletins came to the business office and were never disseminated to the HIM department or because your facility chose not to subscribe to *Coding Clinic* is not a justifiable defense.

- As far as the authorities are concerned, the pertinent payment policies and official coding guidelines were published and available and you "should know."

Source: http://www.warrenbensonlaw.com/medicare-fraud/

Compliance Plans

- Have you heard this……
  - The need for healthcare organizations to develop and implement a compliance program is transitioning from voluntary to mandatory with the passing of the Patient Protection and Affordable Care Act (PPACA), passed in 2010, which now requires healthcare providers to have a compliance program in place when they enroll in Medicare.

Compliance Plans

- Is it true that at this moment, a physician practice **MUST** have an active compliance plan in place?

1. Yes

2. No

Compliance Plans

- Answer – No, but almost!

- Excerpt from CMS-1686-FC (Final Rule) February 2, 2011
  - "2. Proposed Ethics and Compliance Program Provisions In order to consider the views of industry stakeholders, we solicited comments on compliance program requirements included in the ACA. ***We do not intend to finalize compliance plan requirements in this final rule*** with comment period; rather, we intend to do further rulemaking on compliance plan requirements and will advance specific proposals at some point in the future. We were most interested in receiving comments on the following:
    - The use of the seven elements of an effective compliance and ethics program as described in Chapter 8 of the U.S. Federal Sentencing Guidelines Manual (*http://www.ussc.gov/2010guid/20100503_Reader_Friendly_Proposed_Amendments.pdf, pp. 31–35) as the* basis for the core elements of the required compliance programs for Medicare, Medicaid and CHIP enrollment.

To review Final Rule and specifically this excerpt, see page 5942 of CMS-1686-FC – 2/2/11
http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf

Compliance Plans

FINAL MEDICARE SCREENING REQUIREMENTS PUBLISHED, BUT MANDATORY COMPLIANCE PROGRAM REQUIREMENTS STILL PENDING

Adrienne Dresevic, Esq.
Carey F. Kalmowitz, Esq.
THE HEALTH LAW PARTNERS, P.C.

On February 2, 2011, the Centers for Medicare and Medicaid Services ("CMS") published its final rule for establishing new screening requirements for enrollees in Medicare, Medicaid, and the Children's Health Insurance Programs ("CHIP") pursuant to Section 6401(a) of the Patient Protection and Affordable Care Act ("PPACA") (the "Final Rule").[1] Prior to PPACA's enactment, provider and supplier screening was not part of the Medicare enrollment process. The Final Rule will be effective on March 25, 2011 for newly enrolling providers and suppliers as well as for currently enrolled providers and suppliers whose revalidation cycle ends between March 25, 2011 and March 25, 2012. For all other currently enrolled providers and suppliers, the effective date for this Final Rule will be March 25, 2012.

Continued…….

Compliance Plans

The Final Rule also addressed the compliance program requirement as set forth in Section 6401 of PPACA, which prescribes that, as a condition of enrolling in Medicare, Medicaid or CHIP, providers and suppliers must establish compliance programs that meet certain "core elements." Notably, at this time, CMS did not finalize any rules related to mandatory compliance. Instead, CMS continues to do further rulemaking and will "advance specific proposals at some time in the future." The September 23, 2010 Proposed Rule solicited comments on these "core elements." While the Final Rule did not finalize the compliance plan requirements, all providers and suppliers should remain attentive to the developments of the core elements to ensure full compliance with the future rule.

This Final Rule is, yet another, indication that, in its attempt to minimize fraud, waste and abuse, CMS will continue to scrutinize all providers and suppliers, including physicians. Physicians should remain alert for developments relating to the mandatory compliance program requirements.

http://www.thehealthlawpartners.com/docs/20110228_mmlr_medicare_enrollment_screening_process_nm_add.pdf

Compliance Plans

- Being Prepared…..
  - Compliance Plan must be effective and "active"
  - Should demonstrate periodic review and follow through
  - Should document periodic audits
  - Should be kept current;
    - perform training on and distribute information about the program's standards and procedures
    - monitor, audit, and evaluate the program, as well as provide a method for anonymous or confidential reporting
    - respond appropriately when inappropriate conduct is found

- A complete list of the standards for an effective compliance and ethics program can be found at: https://www.cms.gov/MedicareContractingReform/Downloads/compliance.pdf

Improper Payment Information Act of 2002 (IPIA)

- Defines "improper payment as:
  - Payments that…
    - should not have been made, or
    - payments made in an incorrect amount
      - (including overpayments and underpayments)

Improper Payment Information Act of 2002 (IPIA)

- Which would be considered an improper payment?

1. payment to an ineligible recipient
2. payment for an ineligible service
3. any duplicate payment
4. payment for services not received
5. all of the above

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Who's Looking for Improper Payments?

- Which Acronym below is NOT a type of Auditing body…

1. CERT
2. RAC
3. MAC
4. CAC

Who's Looking for Improper Payments?

- Which Acronym below is NOT a type of Auditing body…
  1. CERT
  2. RAC
  3. MAC
  4. **CAC – Carrier Advisory Committee**

Physicians on this committee advise state Carrier Medical directors (CMDs) about coverage policies and impact on their specialty and patient care

Who's Looking for Improper Payments?

CERT

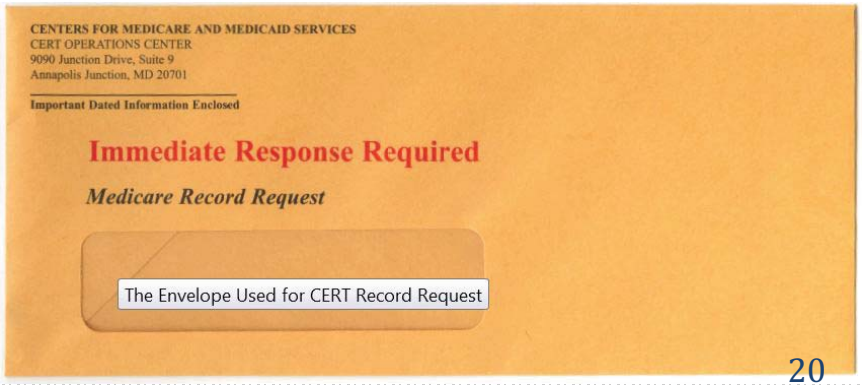
- What Does This Acronym Stand For?
  1. Complete Error Recovery Testing
  2. Corrective Error Recovery Table
  3. Comprehensive Error Rate Testing
  4. Corrective Error Rate Testing
  5. None of the above

Who's Looking for Improper Payments?

- CERT - a program integrity activity that the Centers for Medicare & Medicaid Services (CMS) established to monitor the accuracy of the Medicare Fee-For-Service program.

  - What Does This Acronym Stand For?

    1. Complete Error Recovery Testing
    2. Corrective Error Recovery Table
    3. **Comprehensive Error Rate Testing**
    4. Corrective Error Rate Testing
    5. None of the above



Who's Looking for Improper Payments?

- CERT – ***Changed***…… More Stringent Review Criteria

  - Records from the treating physician not submitted or incomplete
    - In the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history, then apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.

  - Missing evidence of the treating physician's intent to order diagnostic tests
    - In the past, CERT would consider an unsigned requisition or physicians' signatures on test results. Now, CERT requires evidence of the treating physician's intent to order tests, including signed orders and/or progress notes.

  - Medical records from the treating physician did not substantiate what was billed
    - Again, in the past, CERT would review available documentation, including physician orders, supplier documentation, and patient billing history, then apply clinical review judgment. Now, CERT requires medical records from the treating physician and does not review other available documentation or apply clinical review judgment.

  - Missing or illegible signatures on medical record documentation
    - In the past, CERT would apply clinical review judgment in considering medical record entries with missing or illegible signatures. Now, CERT disallows entries if a signature is missing or illegible.

Signature Attestation Statement

On March, 16, 2010, CMS issued CR#6698 that clarified Medicare Fee-for-Service signature requirements. Attached is an example of an attestation statement that can be used. For more information, please visit http://www.cms.hhs.gov/transmittals/downloads/R327PI.pdf

Signature Attestation Statement

Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and **must contain sufficient information to identify the beneficiary**.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

> *"I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials,e.g.,M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. "*

While this is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

Who's Looking for Improper Payments?

- CERT

Who are the CERT Contractor(s)?

Company	Responsible for	Contact Information
Livanta - CERT Documentation Contractor	Obtaining the CERT submitted documentation from providers	9090 Junction Drive, Suite 9 Annapolis Junction, MD 20701 Phone: (888) 779-7477 or (301) 957-2380 Fax: (240)-568-6222
AdvanceMed - CERT Review Contractor	Reviewing the CERT submitted documentation forwarded by Livanta	1530 E. Parham Road Richmond, Virginia 23228 Phone: (804) 264-1778

Who's Looking for Improper Payments?

- CERT - Tidbits

We are a large clinic. Medicare denied a claim for an administration of a drug provided by the nurse in the infusion clinic. The supervising physician today in the clinic was not the same physician who ordered the drug. What information do I need to supply?

Medicare can pay for the services provided by ancillary staff when the situation meets the incident to guidelines. Medicare describes these in the Centers for Medicare & Medicare Services (CMS) Internet Only Manual (IOM) Publication 100-02, Chapter 15, Section 60. This information in Section 60.3 shows that in a clinic setting, the supervising physician and the ordering physician may not be the same person. The documentation should include all the elements requested in the development letter. The document must show the supervision of the service and must provide the medical record documentation from the ordering physician showing the frequency and dosage of the drug.

Who's Looking for Improper Payments?

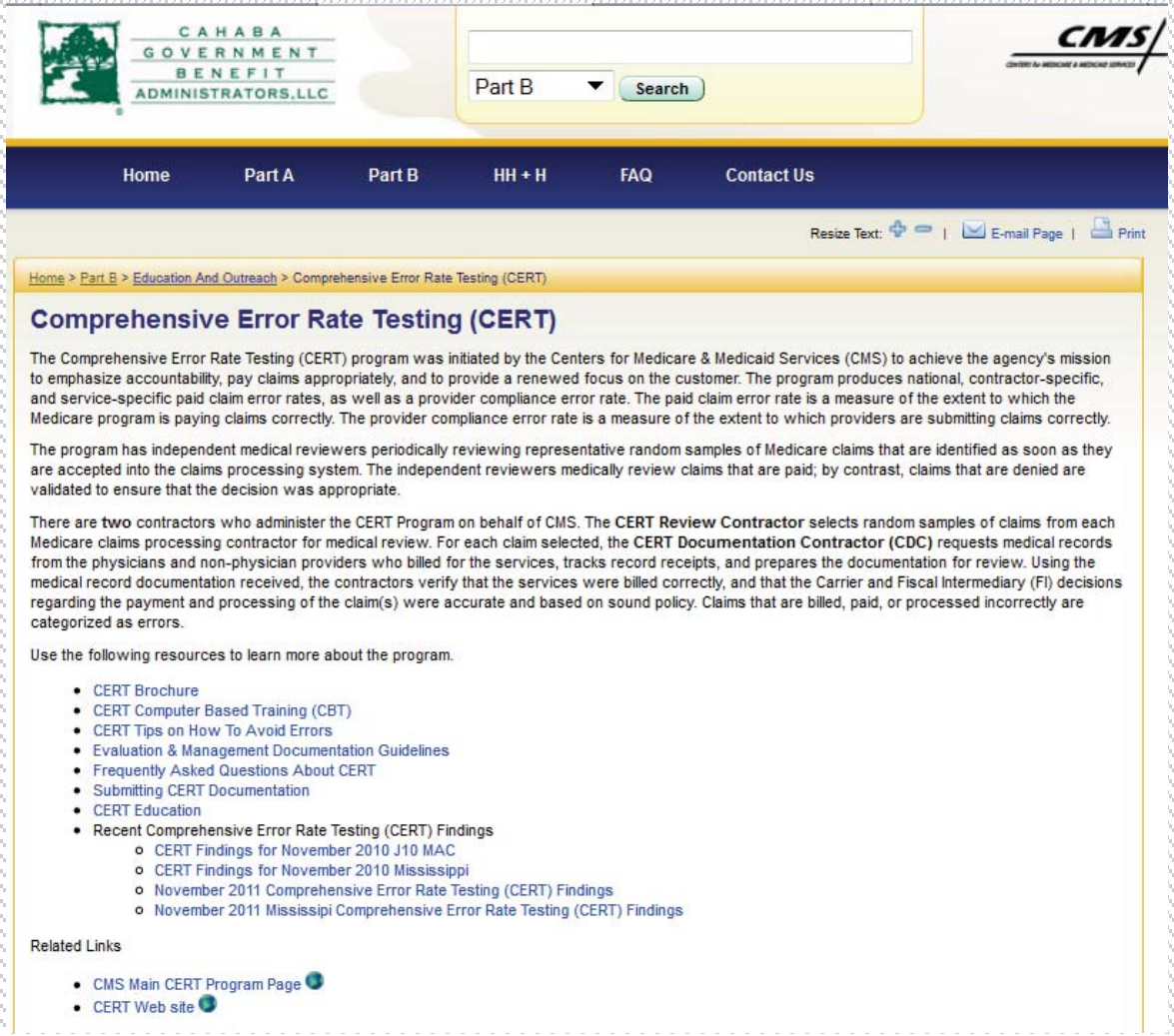
- CERT-Tidbits

I provided a complete blood count (CBC) with differential for a Medicare patient. The CERT contractor recoded my claim to a CBC without differential. Why?

Clinical lab services do not require a signed physician order as part of the documentation, but they do require an order or requisition for the service. In addition, the order should be clear as to what is ordered. If there is no signed order, a progress note documenting the intent of that specific test be performed should be submitted. In most of our recent error findings for a complete blood count with differential, the physician's order showed only a complete blood count. If the order does not show the medical necessity of the service, the lab may request additional documentation from the physician's office to support the medical necessity of the service.

Who's Looking for Improper Payments?

- CERT – Tidbits
  - Keep an eye on your Carrier website



So Much Info!

Who's Looking for Improper Payments?

- CERT –Tidbits
  - Keep an eye on other MACs and CMS site for trends….

https://www.cms.gov/cert/

U.S. Department of Health & Human Services

CMS Centers for Medicare & Medicaid Services

Home | Medicare | Medicaid | CHIP | About CMS | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education | Tools

People with Medicare & Medicaid | Questions | Careers | Newsroom | Contact CMS | Acronyms | Help | Email | Print

CMS Home > Research, Statistics, Data and Systems > Comprehensive Error Rate Testing (CERT) > Overview

Comprehensive Error Rate Testing (CERT)

- **Overview**
- Providers
- CERT Reports and Data
- CERT Reports

Overview

The Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program to measure
(FFS) program. CERT is designed to comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA); Public Law 1
Services (HHS) Office of Inspector General (OIG) estimated the Medicare FFS error rate from 1996 through 2002. The OIG designed
Medicare FFS paid claims error rate. Due to the sample size – approximately 6,000 claims – the OIG was unable to produce error ra
type, or provider type. Following recommendations from the OIG, the sample size was increased for the CERT program when CMS b
November 2003 Report.This methodology includes:CERT randomly selecting a sample of approximately 50,000 claims submitted to C
period. Requesting medical records from the health care providers that submitted the claims in the sample. Where medical records
claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rul
Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an
letters/notices or making adjustments for claims that were overpaid or underpaid.The CERT program cannot be considered a measu
samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payn
and cannot, label a claim fraudulent.All public reports produced by the CERT program are available through the "CERT Reports" link

Downloads

CERT 101 Presentation [PDF, 623 KB]

Overview of Improper Payment Reviews [PDF, 276 KB]

Electronic Submission of Medical Documentation (ESMD) Introduction [PDF, 929 KB]

Related Links Inside CMS

CMS Press Releases

Press Release - NEW STANDARDS HELPING LOWER MEDICARE IMPROPER PAYMENT RATES FOR 2010

Press Release - HHS EMPLOYS NEW TOUGHER STANDARDS IN CALCULATION OF IMPROPER MEDICARE PAYMENT RATES FOR 2009

Press Release - CMS ISSUES IMPROPER PAYMENT RATES FOR MEDICARE, MEDICAID, AND SCHIP

Press Release - MEDICARE CONTINUES TO REDUCE IMPROPER CLAIMS PAYMENTS

Press Release - MEDICARE REDUCES IMPROPER CLAIMS PAYMENTS BY HALF

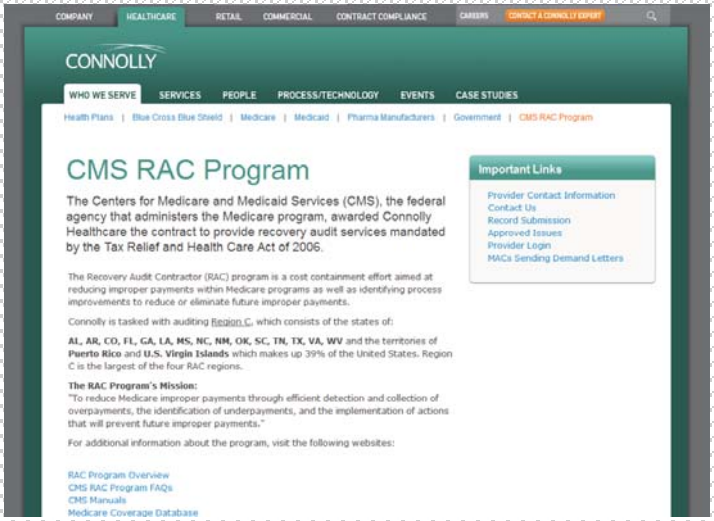
Press Release - CMS ANNOUNCES IMPROVED EFFORTS TO REDUCE MEDICARE PAYMENT ERROR RATES

Who's Looking for Improper Payments?

- RAC (Recovery Audit Contractor)
  - Who is the RAC for Georgia?
    1. Diversified Collection Services (DCS)
    2. CGI Technologies
    3. Connolly, Inc.
    4. Health Data Insights (HDI)
    5. None of the above

Who's Looking for Improper Payments?

- RAC (Recovery Audit Contractor)
  - Who is the RAC for Georgia?
    1. Diversified Collection Services (DCS)
    2. CGI Technologies
    3. Connolly Consulting
    4. Health Data Insights (HDI)
    5. None of the above



http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx

Who's Looking for Improper Payments?

- RAC

- How many here today have had a RAC audit?

1. Yes, I have had a RAC audit

2. No, I have not had a RAC audit

Who's Looking for Improper Payments?

- RAC
  - How far back can a RAC review?
    1. January 1, 2007
    2. 1 year from the claim paid date
    3. 2 years from the claim paid date
    4. 3 years from the claim paid date
    5. None of the above

Who's Looking for Improper Payments?

- RAC
  - How far back can a RAC review?
    1. January 1, 2007
    2. 1 year from the claim paid date
    3. 2 years from the claim paid date
    4. **3 years from the claim paid date**
    5. None of the above

Who's Looking for Improper Payments?

- RAC
  - When records are requested by the RAC, providers have how many days to return records?

1. 30
2. 45
3. 60
4. 90

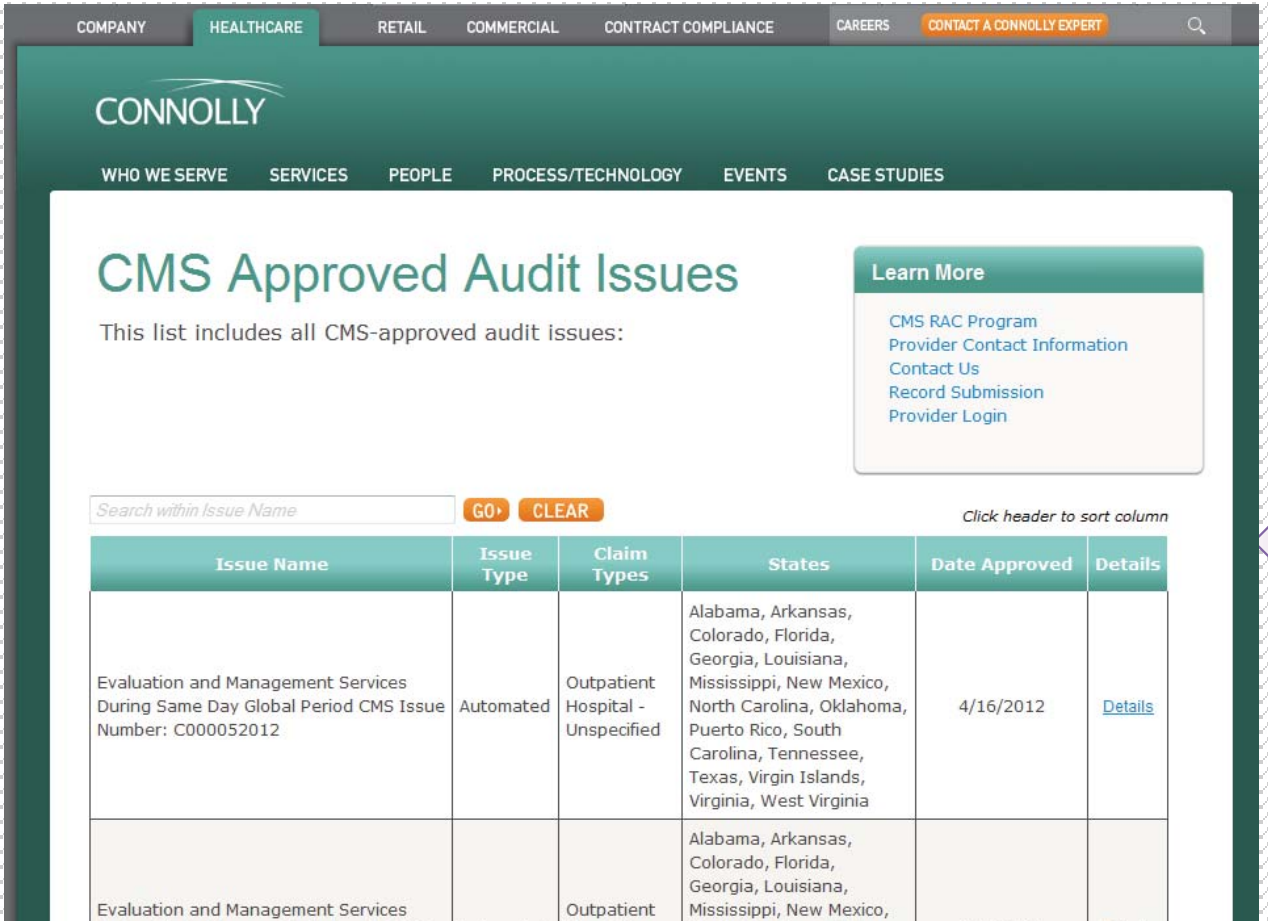
Who's Looking for Improper Payments?

- RAC
  - When records are requested by the RAC, providers have how many days to return records?
    1. 30
    2. 45
    3. 60
    4. 90

- This is not much time – all offices should have a point person for all record requests (from anyone) and be aware of timelines!

Who's Looking for Improper Payments?

- RAC
  - Keep an eye on the "**Issues List**" and



You'll find:
New Patient Visits
Colony Stimulating Factors
Palonosetron (Dose vs Units)
Dolasetron
Rituximab
Fulvestrant
Filgastim
Leuprolide Acetate
Cetuximab
Paclitaxel
Correctly Bill MUE Codes
Ad On Codes
Hospice

Sort by Issue, Provider Type or Date!

- RAC
  - FY 2010 FFS Recovery Audit Program Results

- RAC Demonstration findings: www.cms.gov/rac

Table B4. Corrections by Recovery Auditor and Part A, B, and DME C

Recovery Auditor	Claim Type	Demanded			Collected		
		No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($)	Mean Claim Amount ($)
Region A: DCS	Part A	1,575	$5,422,904	$3,443	868	$3,596,894	$4,144
	Part B	283	33,489	118	468	48,664	104
	DME	11,250	1,432,085	127	8,520	1,039,500	122
Region B: CGI	Part A	20,718	19,161,234	925	19,974	14,980,649	750
	Part B	2,701	422,748	157	1,805	331,266	184
	DME	3,520	538,623	153	740	105,836	143
Region C: Connolly	Part A	17,323	40,571,168	2,342	14,072	20,643,799	1467
	Part B	106	13,977	132	89	5,057	57
	DME	47,398	9,842,961	208	8,083	3,730,377	462
Region D: HDI	Part A	18,189	21,762,172	1,196	14,285	11,891,663	832
	Part B	118,540	12,575,607	106	52,538	5,087,783	97
	DME	73,680	23,909,625	325	63,623	13,973,988	220
Total		315,283	$135,686,593	$430	185,065	$75,435,476	$408

- RAC – Watching the other RACs will help give an idea where they may look next……

Table C1. Top 4 Issue Codes by Recovery Auditor—Collections

Recovery Auditor	Issue Code	No. of Claims	Total ($)	Mean Claim Amount ($)
Region A: DCS	Ventilator 96+ hours–DRG value	93	$ 1,882,615	$ 20,243
	Cardiac procedures–DRG value	45	325,738	7,239
	Cerebrovascular disease (CVA)–DRG value	115	325,043	2,826
	Multiple DME rentals per month	3,408	311,762	91
Region B: CGI	Unrelated extensive procedure	161	$ 1,681,390	$ 10,443
	Tracheostomy overpayment	14	1,339,325	95,666
	IV infusion chemotherapy	6,483	1,290,135	199
	Excisional debridement	140	1,052,100	7,515
Region C: Connolly	Other respiratory system O.R. procedures with MCC	191	$ 2,549,301	$ 13,347
	DME claims billed during inpatient stay	3,409	1,740,973	511
	Coagulation disorder MD–DRG 813	432	1,674,838	3,877
	Respiratory system diagnosis with ventilator support 96+ hours	75	1,549,888	20,665
Region D: HDI	DME–POS during inpatient stay	22,248	$ 6,578,421	$ 296
	Date of service after death–DME	13,874	1,473,640	106
	Prosthetic bundling	2,134	1,328,000	622
	Untimed codes–Excessive units	5,389	1,038,985	193

RAC Awareness

- From Cahaba Website -

Provider Outreach and Education Part B

Date	Seminar Type	Location
04-26-2012	Chiropractic Services Documentation - 30 Minute Session ***Canceled*** **(Registration closed)**	Webinar
05-03-2012	Chiropractic Services Documentation - 30 Minute Session	Webinar
05-23-2012	HIPAA 5010 ..."The Time is Now!"	Teleconference
06-07-2012	Medicare on the Web: "Website Enhancements in 2012"	Webinar
06-20-2012	Ask Cahaba B: "A Discussion with the Recovery Auditor" ***Coming Soon!***	Teleconference/ Webinar

Who's Looking for Improper Payments?

- OIG – Office of Inspector General
  - Since its 1976 establishment, the Office of Inspector General of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs.
    - OIG 2012 "Work Plan" (released on October 1, 2011)

    - Which Item below is not a NEW item on the OIG "Work Plan"?
      1. High Cumulative Part B Payments
      2. Evaluation and Management Services: Trends in Coding of Claims
      3. Payments for Off-Label Anticancer Pharmaceuticals and Biologicals
      4. Physician-Administered Drugs and Biologicals
      5. Medicare Payments for the Drug Herceptin

http://oig.hhs.gov/reports-and-publications/workplan/index.asp

Who's Looking for Improper Payments?

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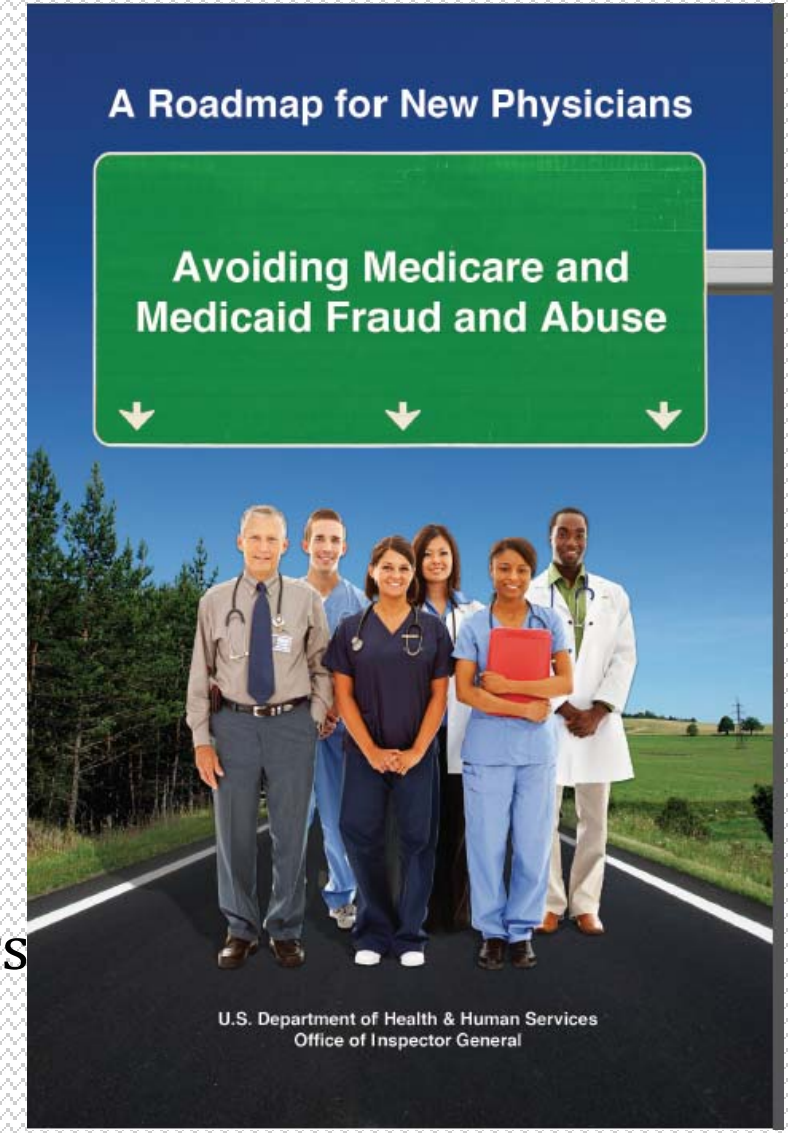
    5. Medicare Payments for the Drug Herceptin
- THEY ARE LOOKING NOW!
  - Do you bill all the same level? Are you an EASY target?

Who's Looking?

- OIG - Learn about…..
  - Fraud and Abuse Laws
    - False Claims Act
    - Anti-Kickback
    - Self Referral
    - Exclusion Statute
    - Civil Monetary Penalties Law
  - Physician Relationships with Payers
  - Physician Relationships with Vendors
  - Compliance Programs
  - Where to go for Help
  - What to Do If You Think You have a problem



http://www.oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf

Audit Yourself First

- Who What How Where When Why…and now what?
- **Answers should be in your Compliance Plan**
  - What to review
    - Evaluation and management (E&M) services
    - Injections
    - Procedures
    - Diagnostic tests

Audit Yourself First

- What do you do if during your self audit you unveil a significant issue where you were inappropriately reimbursed by any payer for a service or services?
  - You should…..
    1. Immediately make a copy of all the EOB's, write a check and send it to the payer
    2. Fix the problem for all future billings document your compliance plan
    3. Contact a healthcare attorney
    4. Ignore the request and make them ask more than once

Audit Yourself First

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UNITED STATES DEPARTMENT of JUSTICE

THE UNITED STATES ATTORNEY'S OFFICE
EASTERN DISTRICT of MICHIGAN

SEARCH THE SITE
Search SEARCH

ST. MARY'S OF MICHIGAN PAYS $3.49 MILLION IN VOLUNTARY DISCLOSURE OF IMPROPER BILLING FOR CHEMOTHERAPY

Claim Relates To Supervision Of Chemotherapy Infusions In Bad Axe, Michigan

FOR IMMEDIATE RELEASE

September 27, 2011

DETROIT – St. Mary's of Michigan, a non-profit entity that owns and operates the Seton Cancer Institute and other health care facilities in Michigan, has agreed to pay the United States $3.49 million as a result of its voluntary disclosure that its billing for chemotherapy infusions performed in Bad Axe, Michigan did not comply with Medicare and Medicaid requirements over a period of seven years, the U.S. Attorney's Office in Detroit announced today.

Medicare and Medicaid rules prohibit any billing for chemotherapy performed in an outpatient clinic setting unless there is a physician available within the clinic when chemotherapy is administered. Until April 1, 2011, St. Mary's operated an oncology clinic within leased space in the Huron Medical Center in Bad Axe, Michigan and administered chemotherapy there three or four days a week without a physician present in the clinic. St. Mary's discovered the problem through a self-audit and brought it to the attention of federal authorities.

U.S. Attorney Barbara McQuade praised St. Mary's and John R. Graham, St. Mary's President and Chief Executive Officer, for instituting a self-audit procedure, for ceasing the conduct on its own initiative and for coming forward to disclose it.

"We applaud the legitimate providers who are responsible participants in the Medicare program," said McQuade. "Too many health care providers do not take appropriate steps to ensure that their claims to Medicare are legitimate. We encourage other providers in our area to follow St. Mary's example."

The case was handled by the U.S. Attorney's Office for the Eastern District of Michigan, the Michigan State Office of the Attorney General, the Office of Inspector General of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services.

Self Reported "Incident T Violation!

http://www.justice.gov/usao/mie/news/2011/2011_9-28_stmary.html

Where are you?

- Place of Service
  - **Place-of-Service Codes Caused $13 Million in Overpayments**
    - Entering your place-of-service (POS) number on your claim form may seem routine, but a recent OIG audit found that practices are not giving POS numbers the care they deserve.
      - Based on a review of 100 non-facility Part B claims from 2007, the OIG found that only 10 of the sampled claims had the correct POS code assigned to it, resulting in overpayments of over $4,700.
        - Based on the sample, the OIG estimated that Medicare nationally overpaid physicians $13.8 million in POS coding errors, according to the report.
  - OIG Reports:
    - www.oig.hhs.gov/reports.asp
    - http://oig.hhs.gov/reports-and-publications/workplan/index.asp#current
  - Location of Codes
    - Medicare Claims Processing Manual, Chapter 26, Section 10.5 - Place of Service Codes (POS) and Definitions [PDF, 601KB]

Who are you?

- Incident to:
  - From the OIG 2012 Work plan:

Physicians: Incident-To Services (New)

We will review physician billing for "incident-to" services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess CMS's ability to monitor services billed as "incident-to." Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians' billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not perform personally. Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality. Medicare's Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) (OEI; 00-00-00000; expected issue date: FY 2013; new start)

Incident To

- Is the supervising physician required to read and co-sign a midlevel provider's history and physical, progress note or other documentation?

1. Yes

2. No

Incident To

- Is a the supervising physician required to read and cosign a midlevel provider's history and physical, progress note or other documentation?

1. Yes

2. No

Documentation:

The progress note must substantiate the service performed and be signed by the person performing it.

When the physician is involved with a particular service, his or her contribution to the care must be documented. This will assist in substantiating his or her continued involvement in the patient's care.

The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainly of the situation.

All documentation should support the level of care provided.

Excerpt from :

National Coverage Provision

Incident to a Physician's Professional Service in the Office or Clinic

E & M

- New vs Established Patient

  - Patient never seen in office. Previously seen by another physician from our group practice 2.5 years ago for a benign hematology problem. Patient presents today for recently diagnosed cancer.

    1. New
    2. Established

E & M

- New vs Established Patient
  - Patient never seen in office. Previously seen by another physician from our group practice 2.5 years ago for a benign hematology problem. Patient presents today for recently diagnosed cancer.
    1. New
    2. **Established**

- Even if the problem is new or it is a different physician in the same group practice/same specialty, they are still considered an "established" patient
  - Hematology Oncology is usually considered one specialty

E & M

- New vs Established Patient

  - Patient had surgery for a hernia 2.5 years ago by a physician in our group practice. Presented today for a recently diagnosed colon cancer.

    1. New
    2. Established

E & M

- New vs Established Patient
  - Patient had surgery for a hernia 2.5 years ago by a physician in our group practice. Presented today for recently diagnosed colon cancer.
    1. New
    2. Established
- As long as the patient is seen by a different specialty, even within the same group, they can be considered a “new” patient.

E & M

- New vs Established Patient

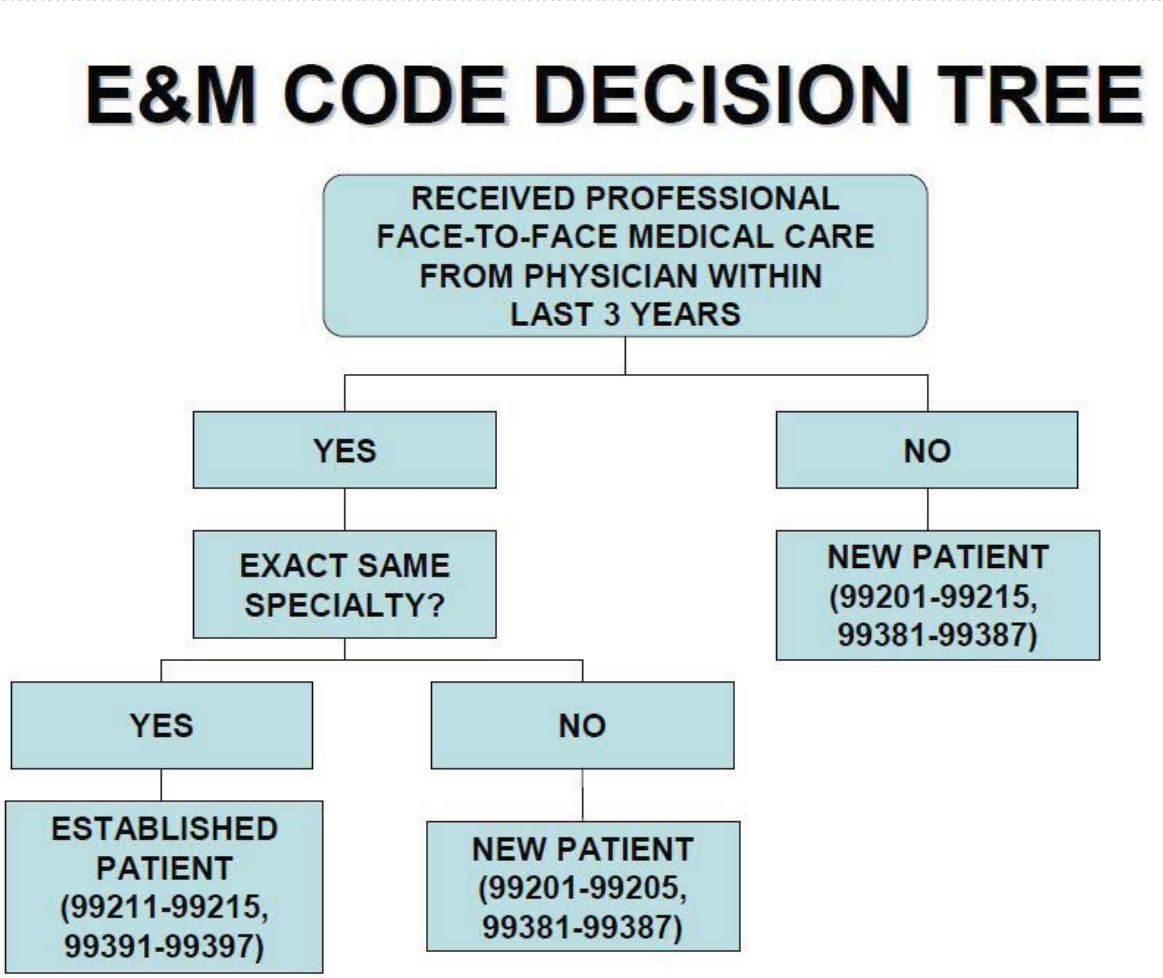
  - Patient last seen for follow up of colon cancer 4 years ago by a physician in our group practice. Presented today to see the same physician for *recurrence of colon cancer*.

    1. New
    2. Established

E & M

- New vs Established Patient
  - Patient last seen for follow up of colon cancer 4 years ago by a physician in our group practice. Presented today to see the same physician for *recurrence of colon cancer*.
    1. New
    2. Established
- Always a new patient if not seen by the group practice within the last 3 years

E & M


E&M CODE DECISION TREE
RECEIVED PROFESSIONAL FACE-TO-FACE MEDICAL CARE FROM PHYSICIAN WITHIN LAST 3 YEARS
YES
NO
EXACT SAME SPECIALTY?
NEW PATIENT (99201-99215, 99381-99387)
YES
NO
ESTABLISHED PATIENT (99211-99215, 99391-99397)
NEW PATIENT (99201-99205, 99381-99387)

E & M

- Under the CPT guidelines, which item below is not considered a KEY component in selecting the level of service?
  1. History
  2. Examination
  3. Medical Decision-making
  4. Counseling and Coordination of Care

E & M

- Under the CPT guidelines, which item below is not considered a KEY component in selecting the level of service?
  1. History
  2. Examination
  3. Medical Decision-making
  4. Counseling and Coordination of Care

E & M

- *A patient presents for an office visit after preliminary work-up. The physician sees the patient in his office and discusses the treatment options and subsequent lifestyle effects of the treatment for 40 minutes. The physician did not complete a history or physical exam.*

- What level of service can the physician bill?

1. Level 1 – 99211
2. Level 3 – 99213
3. Level 4 – 99214
4. Level 5 – 99215
5. The physician cannot bill for this service

E & M

- *A patient presents for an office visit after preliminary work-up. The physician sees the patient in his office and discusses the treatment options and subsequent lifestyle effects of the treatment for 40 minutes. The physician did not complete a history or physical exam.*

- What level of service can the physician bill?
  1. Level 1 – 99211
  2. Level 3 – 99213
  3. Level 4 – 99214
  4. Level 5 – 99215
  5. The physician cannot bill for this service

- Next slide reviews the "time" related to levels of service

New Patient Visit Time

99201
10 minutes

99202
20 minutes

99203
30 minutes

99204
45 minutes

99205
60 minutes

Established Patient Visit Time

99211
5 minutes

99212
10 minutes

99213
15 minutes

99214
25 minutes

99215
40 minutes

Initial Hospital Care Time

99221
30 minutes

99222
50 minutes

99223
70 minutes

Subsequent Hospital Care Time

99231
15 minutes

99232
25 minutes

99233
35 minutes

E & M

- Billing based on time…..
  - Physician is face to face with an established patient in the office for 35 minutes, however, he did not examine the patient and just discussed the change in treatment, recommended testing and answered the patient's questions. Which code would you bill?
    1. 99214 (25 min)
    2. 99215 (40 min)
    3. You can't bill because he did not perform an exam
    4. Beats the heck out of me!

E & M

- Billing based on time…..
  - Physician is face to face with an established patient in the office for 35 minutes, however, he did not examine the patient and just discussed the change in treatment, recommended testing and answered the patient's questions. . Which code would you bill?
    1. 99214 (25 min)
    2. **99215 (40 min)**
    3. You can't bill because he did not perform an exam
    4. Beats the heck out of me!

- CPT Assistant, August 2004 / Volume 14, Issue 8, page 3
  - *"In selecting time, the physician must have spent a time closest to the code selected.*
    - *For example, 99214 has a typical time of 25 minutes and 99213 has a typical time of 15 minutes. If the face-to-face office time is 21 minutes, code 99214 would be selected as it is more than half of the time difference."*

CPT and CPT Assistant available on the AMA site: www.ama-assn.org

E & M

- Billing based on time…
  - What % of time must the counseling and coordination of care dominate?

1. At least 50%
2. More than 50%
3. 75%
4. 100%

E & M

- Billing based on time…
  - What % of time must the counseling and coordination of care dominate?

1. At least 50%
2. More than 50%
3. 75%
4. 100%

E & M

- Billing based on time….

  - In the office setting, which component below cannot be included when determining time?
    1. Time spent face to face with the patient counseling the patient
    2. Time spent examining the patient
    3. Time spent answering questions from the patient's family with the patient in the same room
    4. Time spent after the visit coordinating care with another physician
    5. None of the above

E & M

- Billing based on time….
  - In the office setting, which component below cannot be included when determining time?
    1. Time spent face to face with the patient counseling the patient
    2. Time spent examining the patient
    3. Time spent answering questions from the patient's family with the patient in the same room
    4. Time spent after the visit coordinating care with another physician
    5. None of the above

E & M

- Billing using time…
  - In the hospital setting, which component below cannot be included when determining time?
    1. Time down the hall from the patient's room communicating with the patient's family
    2. Time spent in pathology department reviewing patient's findings
    3. Time at the bedside discussing test results
    4. Time at the bedside reviewing chart
    5. Time at the nurses' station (same floor) reviewing test results

E & M

- Billing using time…
  - In the hospital setting, which component below cannot be included when determining time?
    1. Time down the hall from the patient's room communicating with the patient's family
    2. Time spent in pathology department reviewing patient's findings
    3. Time at the bedside discussing test results
    4. Time at the bedside reviewing chart
    5. Time at the nurses station (same floor) reviewing test results

E & M

- Billing based on time –
  - Documentation required components
    - Total face to face/ floor time
    - More than 50% spent counseling and coordinating care
    - Summary counseling topics and/or how time was spent coordinating the patient's care

4. Time

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time?	Time:	Face-to-Face in outpatient setting Unit/floor in inpatient setting	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?			☐ Yes	☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?			☐ Yes	☐ No

If all answers are "yes," select level based on time.

If the components of time are documented , this trumps other documentation and will be used for level determination

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

E & M

- If a physician has established the level of service based on time but spends a long time with the patient, can you also consider billing the prolonged add-on code?

1. Yes

2. No

E & M

- If a physician has established the level of service based on time and a prolonged time occurs, can you also bill for the prolonged add-on code?

1. Yes
2. No

  - The prolonged codes are "add on" codes and as long as you meet the time requirements, it would be appropriate
  - 99354 – 99357 prolonged codes **do** require face to face time in both the outpatient hospital and office setting
  - Prolonged time of less than 30 minutes **cannot** be reported separately

E & M

- Prolonged Services

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115

E & M

- Prolonged Services…
  - *A physician performed a visit which met the criteria of an office visit code 99213-based on history, exam and medical decision making, less than 50% was spend counseling and coordinating care. The total duration of the direct face-to-face service was 65 minutes.*
  - What would the physician bill?
    1. 99213 (15) alone
    2. 99213 (15) and 99354 (>30)
    3. 99214 (25)
    4. 99214 (25) and 99354 (>30)
    5. 99215 (40)
    6. Beats me and I'm getting a headache

E & M

- Prolonged Services…
  - *A physician performed a visit which met the criteria of an office visit code 99213-based on history, exam and medical decision making, less than 50% was spend counseling and coordinating care. The total duration of the direct face-to-face service was 65 minutes.*
  - What would the physician bill?
    1. 99213 (15) alone
    2. 99213 (15) and 99354 (>30)
    3. 99214 (25)
    4. 99214 (25) and 99354 (>30)
    5. 99215 (40)
    6. Beats me and I'm getting a headache

E & M

- Prolonged Services
  - Physician spends 60 minutes with a patient counseling and coordinating care;
  - Which would you bill?
    1. 99214 (25) plus 99354 (>30)
    2. 99215 (40) plus 99354 (>30)
    3. 99215 (40) alone
    4. None of the above

E & M

- Prolonged Services
  - Physician spends 60 minutes with a patient counseling and coordinating care;
  - Which would you bill?
    1. 99214 (25) plus 99354 (>30)
    2. 99215 (40) plus 99354 (>30)
    3. 99215 (40) alone
    4. None of the above

**See next slide for explanation

E & M

- ***H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)***
  - *"When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be "rounded" to the next higher level."*
  - *"In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code. "*

**http://www.cms.gov/transmittals/downloads/R1490CP.pdf

E & M

- Prolonged Services -
  - What is the approximate Medicare reimbursement for the 99354
    - prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour

1. $25.00
2. $55.00
3. $95.00
4. $115.00

E & M

- Prolonged Services -
  - What is the approximate reimbursement for the 99354
    - prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour

1. $25.00
2. $55.00
3. $95.00
4. $115.00

E & M

- Prolonged Services
  - What is the approximate reimbursement for the 99355
    - prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; Additional 30 minutes

1. $25.00
2. $55.00
3. $95.00
4. $115.00

E & M

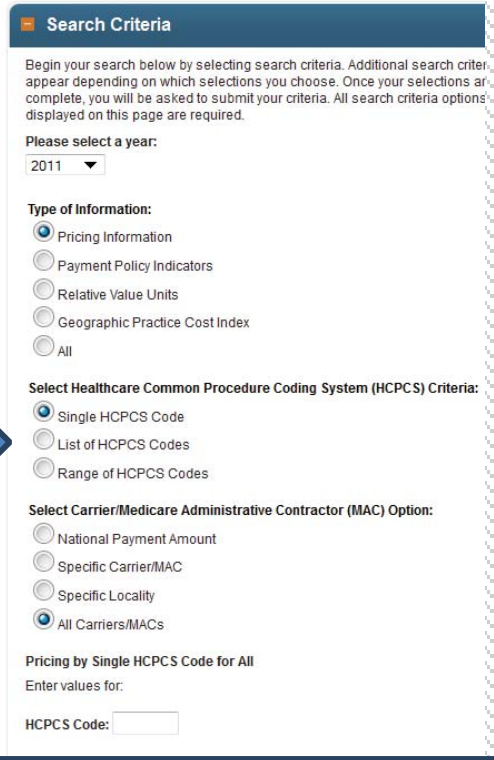
- Prolonged Services
  - What is the approximate reimbursement for the 99355
    - prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; Additional 30 minutes

1. $25.00
2. $55.00
3. $95.00
4. $115.00

FYI

- CMS Fee Schedule Search

1. Start search



2. Choose options

3. Quick results!

https://www.cms.gov/apps/physician-fee-schedule

E & M

- The Basics…..
  - **All E & M visits must have "Chief Complaint"
    - "A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.
      - WATCH OUT: ***Patient is here for chemo***.
  - 3 KEY components
    - History
    - Examination
    - Medical Decision making

E & M

- Many practices use templates to meet the highest level of care for the History and Examination
  - we will review problems with cloning in a few minutes…..

  - History:
    - History of present Illness (HPI)
      - Documented by physician
    - Review of Systems **
    - Past , family and social history (PFSH)**
      - **Often recorded on an office health history questionnaire completed by patient or ancillary staff & reviewed and SIGNED and DATED by the physician

E & M

Highmark E & M worksheet found at:
https://www.highmarkmedicareservices.com/em/pdf/scoresheets/8985.pdf

- ROS – HISTORY
  - Patient has stage III colon cancer diagnosed in July, 2011 and has been feeling fairly well. There is no family history of cancer. Patient has never been sick before and never goes to the doctor. Patient does not drink or smoke.
  - Review of symptoms: Patient continues to loose weight and has trouble sleeping. Complains of decreased appetite due to GI upset. All other systems negative.

HISTORY								
	HPI (history of present illness): Status of chronic conditions: ✓ 1 condition ☐ 2 conditions ☐ 3 conditions *OR*						✓ Status of 1-2 chronic conditions	☐ Status of 3 chronic conditions
	HPI elements: ✓ Location ☐ Quality ✓ Severity ✓ Duration ✓ Timing ☐ Context ✓ Modifying factors ☐ Associated signs and symptoms						☐ Brief (1-3)	✓ Extended (4 or more)
	ROS (review of systems):					☐ None	☐ Pertinent to problem (1 system)	☐ Extended (2-9 systems)	☐ *Complete ✓
	☐ Constitutional (wt loss, etc.) ☐ Eyes	☐ Ears, nose, mouth, throat ☐ Card/Vasc ☐ Resp	☐ GI ☐ GU ☐ Musculo	☐ Integumentary (Skin, breast) ☐ Neuro ☐ Psych	☐ Endo ☐ Hem/lymph ☐ All/immuno ☐ All others negative				
	PFSH (past medical, family, social history) areas: ✓ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ✓ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient is at risk) ✓ Social history (an age appropriate review of past and current activities)						☐ None	☐ Pertinent (1 history area)	✓ **Complete (2 or 3 history area)
						Problem Focused	Exp. Prob. Focused	Detailed	Comprehensive

*** Complete ROS:** 10 or more systems, or some systems with statement "all others negative." ✓

**** Complete PFSH:** 2 history areas: a) Established patients – office (outpatient) care; b) Emergency department.

3 history areas: a) New patients – office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

E & M

- Can the Review of Systems (ROS) and/or Past, Family, Social History (PFSH) sections of the History component of an Evaluation and Management (E/M) be recorded by ancillary staff?

1. Yes

2. No

E & M

- Can the Review of Systems (ROS) and/or Past, Family, Social History (PFSH) sections of the History component of an Evaluation and Management (E/M) be recorded by ancillary staff?

From the CMS.gov - Q & A portion of website:

- **Yes**, according to the 1995 E/M Documentation Guidelines, The ROS and/or PFSH section of the history component of an E/M may be recorded by ancillary staff. There must be a notation supplementing or confirming the information that was recorded by the ancillary staff member by the physician.
- Date Posted: 10/16/2009, Date Revised: 08/23/2011

Just Released…..

http://www.cgsmedicare.com/ohb/pubs/news/2012/0412/cope18560.html

Non-Physicians Acting as Scribes for Physicians

Recently CGS has noted some physicians having another individual write notes in the medical record for them, and then the physician merely follows behind and signs the note. This may be inappropriate and education is especially important with the increased implementation of Electronic Medical records (EMRs).

If a nurse or Non-Physician Practitioner (NPP) acts as a scribe for the physician, the individual writing the note or entry in the record should note "written by (Jane Doe), acting as scribe for Dr. (Smith)." Then, Dr. (Smith) should co-sign, and indicate the note accurately reflects work and decisions made by the physician. The scribe is functioning as a "living recorder," documenting in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. The real time transcription must be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.

Increasingly, CGS is seeing components of evaluation and management services completed or updated by nursing or other medical staff in the EMR. For example: In the Past Medical or Family/Social History sections, there is an electronic note stating "*updated by Nancy Jones, Medical Technician"* or an electronic statement of "*medication list updated by Mary Smith RN.*" If the physician does not review and address these components as well; and the only documentation relating to these components is the entry from the nurse or a medical technician, then these components may not be used in determining the level of E&M service provided as they do not reflect the work f the physician.

It is also inappropriate for an employee of the physician to round at one time, make entries in the record, and then for the physician to round several hours later and note "agree with above," unless the employee is a licensed, certified NPP billing Medicare for services under the NPP name and number.

Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no "incident to" billing in the hospital setting (in-patient or out-patient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity. The physician is ultimately accountable for the documentation, and should sign and note after the scribe's entry the affirmation above, that the note accurately reflects work done by the physician.

E & M

- Examination
  - Generally – today the physical exam is routine and often documented with templates which constitute a Comprehensive Exam (but was it medically necessary?)
    - Oncology patient follow up – usually yes.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem	**Problem Focused Exam**
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	**Expanded Problem Focused Exam**
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	**Detailed Exam**
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	**Comprehensive Exam**

EXAM								
Body areas: ☐ Head, including face ☐ Back, including spine ☐ Chest, including breast and axillae ☐ Genitalia, groin, buttocks ☐ Abdomen ☐ Each extremity ☐ Neck						☐ 1 body area or system	☐ Up to 7 systems	☐ Up to 7 systems	☐ 8 or more systems
Organ systems: ☐ Constitutional (e.g., vitals, gen app) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm									
						Problem Focused	Exp. Prob. Focused	Detailed	Comprehensive

E & M

- Medical Decision Making (MDM)
  - THIS IS IT –
    - LEARN IT – UNDERSTAND IT – TEACH IT

    - NEVER the same
    - ***In my opinion*** – the KEY factor to determining the level of service
      - Established patient – not required to use MDM but using it seems to keep the level chosen more accurate

      - **WHAT DID YOU DO FOR THIS PATIENT TODAY?**
        - Number of diagnosis OR treatment options
        - Amount and/or complexity of data reviewed (and documented)
        - Risk of Complications and/or Morbidity or Mortality

E & M

- Medical Decision Making –
  - Number of Diagnosis or Treatment Options

Number of Diagnoses or Treatment Options			
A	B X	C =	D
Problem(s) Status	Number	Points	Results
Self-limited or minor (stable, improved, or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add workup planned		4	
		TOTAL	

Multiply the number in columns B & C and put the product in column D.

Enter a total for column D

E & M

- Medical Decision Making
  - Amount and/or Complexity of Data Reviewed
    - **easiest to determine – one CPT code = One point

For each category or reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

E & M

- Medical Decision Making

identified in Final Result for Complexity (table below).

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem, e.g., cold insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest X-rays • EKG/ EBG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or noninsulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Noncardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-Counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illness with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic with no identified risk factors) • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgey (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parental controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

E & M

- Medical Decision Making – Final Result

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity					
A	Number diagnoses or treatment options	≤1 Minimal	2 Limited	3 Multiple	≥4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and Complexity of Data	≤1 Minimal or Low	2 Limited	3 Multiple	≥4 Extensive
Type of decision making		STRAIGHT FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

E & M

A	Number diagnoses or treatment options	≤1 Minimal	2 Limited	3 Multiple	≥4 Extensive
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2 of 3

- Medical Decision Making Example – physician note:
  - Recurrent colon cancer, stage 4
  - Summary
    - Reviewed the results of his recent CT scan which showed his disease advancing and a new mass. I recommended continued chemotherapy however, he has decided he is going to take some time off and travel with his wife for at least a month. I plan on seeing him in follow-up in one month when he returns and at that time a CA125 and CBC w/differential will be done.

    - Example:
      - Established problem worsening (2 pts)
      - Data (2 pts) Labs and CT
      - Risk – High; chemotherapy

E & M – Final Results

5. Level of Service

Outpatient, Consults (Outpatient, Inpatient) and ER

	New Office/Consults/ER Requires 3 components within shaded area					Established Office Requires 2 components within shaded area				
History	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C		PF	EPF	D	C
Complexity of medical decision	SF ER: SF	SF ER: L	L ER: M	M ER: M	H ER: H		SF	L	M	H
Average time (minutes) (ER has no average time)	10 New (99201) 15 Outpt cons (99241) 20 Inpt cons (99251) ER (99281)	20 New (99202) 30 Outpt cons (99242) 40 Inpt cons (99252) ER (99282)	30 New (99203) 40 Outpt cons (99243) 55 Inpt cons (99253) ER (99283)	45 New (99204) 60 Outpt cons (99244) 80 Inpt cons (99254) ER (99284)	60 New (99205) 80 Outpt cons (99245) 110 Inpt cons (99255) ER (99285)		5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
Level	I	II	III	IV	V		I	II	III	IV	V

Inpatient	Initial Hospital/ Observation Requires 3 components within shaded area			Subsequent Hospital Requires 2 components within shaded area		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes) (Observation care has no average time)	30 Init hosp (99221) Observ care (99218)	50 Init hosp (99222) Observ care (99219)	70 Init hosp (99223) Observ care (99220)	15 Subsequent (99231)	25 Subsequent (99232)	35 Subsequent (99233)
Level	I	II	III	I	II	III

- PF = Problem Focused
- EPF = Expanded Problem Focused
- D = Detailed
- C = Comprehensive

E & M

- Cloned Notes - CAUTION
  - OIG Work Plan Item in 2011 and 2012….
  - (OEI; 04i10i00181; 04i10i00182; expected issue date: FY 2012; work in progress)

  - *"Medicare contractors have noted an increased frequency of medical records with identical documentation across services. We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments."*

- Cloned Notes - CAUTION
  - Old paradigm: If it's not documented it wasn't done
  - New: It's documented…was it done? (OIG Inspector quot

- Cloning notes: OIG will search for excessive use of copy/paste.
  - OIG acknowledges convenience but is it used in a way that is accurate?
  - OIG looking for identical documentation across services, especially consistent medical decision making notes
  - Similar but different? What makes a note different enough?
  - Current documentation rules are from 1995, but technology has moved forward

E & M

- Is it ok to "clone" (copy and paste) information from the previous visit to create the current medical record?

1. Yes
2. No
3. Some portions
4. One portion

E & M

- Is it ok to clone part of the visit?
  1. Yes
  2. No
  3. Some portions
  4. **One portion**

- ONE PORTION
  - HPI & ROS – should be from that day
  - Past medical history – YES
    - Past medical, social and family history can be carried from previous note
      - The documentation guidelines state the history doesn't have to be re-documented, not that the work doesn't need to be done.
        - May add – "Family history reviewed, unchanged"
          - BUT what if the family history was blank?

    - Populating note with information from last visit?
      - Dangerous
      - One mistake and the whole note could be thrown out
        - Others too…..

Physician Order

- 1st step in a self audit related to infusions/injections
  - Important elements of a physician chemotherapy order;
    - Drug
    - Dose
    - Route
    - Frequency
    - Date
    - Physician Signature – LEGIBLE
      - Include signature attestations with all record requests!

Physician Order

- Billing Scenario
  - *During the treatment, the patient experienced a reaction. The nurse spoke with the physician and the physician told the nurse to administer 50 mg Benadryl. The nurse documented the verbal order including name of physician, date, medication, dose and route of administration.*
    - Will this pass an audit?

1. Yes
2. No

Physician Order

- Will this pass an audit?
  1. Yes
  2. No

- "Verbal orders that are written, dated, and signed or initialed by a **non-physician health care professional or other staff must also must be dated and signed or initialed by the physician.**"

Physician Order

- **GENERAL Verbal Orders Guidelines**
  - Requirements:
    - Name of physician giving the order
    - Date order is taken
    - Elements of a written order
    - Staff member signature or initials
    - Staff member's credentials
      - ***Note:*** *"Verbal orders that are written, dated, and signed or initialed by a* ***non-physician*** *health care professional or other staff must also be dated and signed or initialed by the physician."*

Drugs and Biologicals

- Top on Audit Radar - Audit Pitfalls
  - Waste billed – not documented
  - Amount given does not match order
    - Incorrect units
  - Drug given off-label (antiemetics)
  - Incomplete order (does not include pre-meds)
  - Missing order/order not signed
  - Different than order – dose, frequency

Drugs and Biologicals

- Single Dose Vial – Waste

- When using a 100 mg single dose vial with 4 hours shelf life after reconstituted – and 3 patients receiving 20 mg each, how do you document and bill for the waste?

1. Bill for waste by dividing waste by all patients who used that vial
2. Bill for waste on the last patient only
3. You can't bill for the waste in this situation

Drugs and Biologicals

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Drugs and Biologicals

- Single Dose Vial – Waste

- ***Billing Examples Using JW Modifier***
- ***Per-Unit Example, Multiple Patients:***
  - A physician schedules three Medicare patients to receive botulinum toxin type A (J0585, botulinum toxin type A, **per unit) on the same day within the designated shelf life of the product. Currently, Botox® is available only in a 100-unit size. Once Botox® is reconstituted in the physician's office, it has a shelf life of only four hours. Often, a patient receives less than a 100-unit dose. The physician administers 30 units to each patient. Your claim for these patients would indicate J0585 billed at quantity 30 (to indicate the amount administered to the patient). Billing J0585 JW is not appropriate for these patients.**

  - Your claim for the last patient receiving Botox® in those four hours is where the remaining 10 units are to be billed to Medicare. Your last patient's claim would indicate J0585 billed at quantity 30 (to indicate the amount administered to the patient) on one detail line. The next detail line would indicate J0585 JW billed at quantity 10 (to indicate the 10 units wasted from the 100-unit vial).

Administration

- Avoid Pitfalls
  - Order must include route of administration
  - Documentation must include;
    - Date of service
    - Route, start/stop time for each drug/fluid
    - Can identify concurrent vs sequential
    - Signature and credentials of individual providing service
      - Include attestation statements when records are requested
  - Understand coding rules;
    - One "initial" code per day
    - Correct class of administration – Chemo vs therapeutic
    - Timing rules
  - Be careful of EMRs which choose the code
    - 90 minute infusions ordered cannot bill 2nd hour even if the nurse documents extra few minutes – MUST be a medically necessary reason

Unsure - ASK!!

- Medicare "Ask the Contractor" calls

Home > Part B > Education And Outreach > Ask Cahaba B Open Door Forums

Cahaba GBA Medicare Part B "Ask Cahaba B"

Cahaba GBA hosts "Ask the Contractor Teleconference" for Part B providers in Alabama, Georgia, Tennessee and Mississippi. This teleconference provides an opportunity to share information, answer questions, and identify problems in a timely way. Participants learn from each other's discussions and receive useful clarifications regarding the different rules and instructions associated with coverage, coding, and payment.

All calls are free of charge and you must register to reserve a phone line. Representatives from departments throughout the Cahaba GBA organization (Medical Review, Provider Contact Center, Claims, Appeals, EDI, Provider Enrollment, MSP, Provider Outreach, and Education, etc.) are available to answer questions and listen to your comments. If you are unable to participate in a scheduled call, a recording is made available in Cahaba University.

Please check the Schedule of Upcoming Events for the date and time of the next scheduled teleconference. Please note that the minutes are posted within 30 days of the event.

Minutes
Wednesday, March 21, 2012
Wednesday, April 20, 2011
December 16, 2010
April 29, 2010
December 16, 2009
September 25, 2009

Thank you for your interest and participation in the Cahaba GBA Medicare Part B program.

Page last updated: April 23, 2012

https://www.cahabagba.com/part_b/education_and_outreach/act.htm

Thank You!

Questions?

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